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III. Medical Necessity

The only limitation on services covered is that they are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an EPSDT screen, periodic or interperiodic, whether or not such services are covered or exceed the benefit limits in the State Plan. Services not covered in the State Plan are covered provided they are described in Section 1905(a) of the Social Security Act. All services determined to be medically necessary will be covered. The Division of Medicaid will require that prior approval be obtained by the provider for medically necessary services which are not covered in the State Plan or which exceed the benefit limits addressed in the State Plan. Prior approval is through plans of care which are submitted by a physician for Division of Medicaid approval. Services requested and approved as a result of the plan of care may be provided by any Medicaid approved provider, as appropriate for the service.

Services in Section 1905(a) available to EPSDT recipients, if medically necessary, and not addressed elsewhere in the State Plan include:

1) Podiatrists' Services
2) Optometrists' Services
3) Chiropractors' Services
4) Dentists'
5) Private Duty Nursing
6) Christian Science Nurses
7) Personal Care Services
8) Case Management Services
9) Respiratory Care Services
10) Organ Transplants
11) Rehabilitative Services

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5. **Physicians' Services:** Hospital visits limited to one (1) per day, except visits to patients in Intensive or Coronary Care Units (ICU or CCU) limited to two (2) per day. Medicaid will pay for services of additional physicians during inpatient hospitalization provided the primary physician certifies to the Division that it was medically necessary for the care of the patient. Physicians will not be reimbursed for hospital visits after the patient has used all allowed hospital days. Nursing home visits limited to thirty-six (36) per fiscal year. Medicaid reimbursement for physician services rendered in the physician's office, outpatient department of a hospital or services rendered in a rural health clinic are limited to a combined total of twelve (12) visits per fiscal year. Ancillary diagnostic procedures are not covered after expiration of twelve (12) authorized physician visits.

All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.

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5b Medical and surgical services by a dentist

Medical and surgical services furnished by a dentist in accordance with section 1905 (a) (5) (B) of the Social Security Act are limited to those to services which a dentist is legally authorized to perform and are covered in the Plan.

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Podiatry services are covered for all Medicaid eligible recipients. This means that the professional services provided by a doctor of podiatric medicine within the scope of applicable state law and licensing requirements (except those services such as routine foot care which are specifically excluded) are reimbursable by the Division of Medicaid.

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Chiropractic services are covered for all Medicaid eligible recipients. This means that a chiropractor's manual manipulation of the spine to correct a subluxation, if an x-ray demonstrates that a subluxation exists for which manipulation is the appropriate treatment, is reimbursable by Medicaid. There shall be no reimbursement for x-rays or other diagnostic of therapeutic services furnished or ordered by a chiropractor.

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6d. Other Practitioners' Services:

Nurse practitioner services. Services furnished by a registered nurse who is licensed and certified by the Mississippi Board of Nursing as a nurse practitioner including, but not limited to, nurse anesthetists, nurse midwives, family nurse practitioners, family planning nurse practitioners, pediatric nurse practitioners, obstetrics-gynecology nurse practitioners and neonatal nurse practitioners, under regulations adopted by the Division.

Disease management services. Disease management services are those provided by specially credentialed pharmacists for Medicaid recipients with specific chronic disease states of diabetes, asthma, lipids, or coagulation. It is a patient-centered concept integrating the pharmacist into the health care team with shared responsibility for disease management and therapeutic outcome. The process provides cost-effective, high-quality health care for patients referred by their physician. The referring physician requests disease management services from any credentialed participating pharmacist in Mississippi. With the appropriate transfer of pharmacy care records, including a written referral from the physician to the pharmacist, the referral is considered documented. All laboratory test results must be included because the pharmacist is not allowed reimbursement for laboratory procedures. In order to be cost-effective for the Medicaid program, the disease management services performed by the pharmacist cannot duplicate those provided by the physician.

The pharmacist is knowledgeable about pharmaceutical products and the design of therapeutic approaches which are safe, effective, and cost-efficient for patient outcomes. The pharmacist evaluates the patient and consults with the physician concerning the suggested/prescribed drug therapy. After the drug therapy review with the physician, the pharmacist counsels the patient concerning such topics as compliance and provides the patient with educational and informational materials specific to the disease or drug. The

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pharmacist functions in an educational capacity to ensure the patient understands and complies with the proper usage of all drugs prescribed by the physician. The involvement with the patient and the education of the patient about lifestyle changes and improved drug regimen compliance are aimed at reduction of or avoidance of costly hospitalizations and emergency care.

The State Pharmacy Practice Act in its Disease Management Protocol requires communication with the referring physician. Disease management services follow a protocol developed between the pharmacist and patient's physician. When nationally accepted clinical practice guidelines are introduced, they will be incorporated into the individual patient's therapy plan.

The primary components of this service are as follows:

1. Patient evaluation
2. Compliance assessment
3. Drug therapy review
4. Disease state management according to clinical practice guidelines
5. Patient/caregiver education

A copy of the pharmacy care records, including the documentation for services, is shared with the patient's physician and remains on file in the pharmacist's facility available for audit by the Division of Medicaid.

To provide this service, a pharmacist must be a registered pharmacist with a doctorate in pharmacy or a registered pharmacist who has completed a disease specific certification program approved by the Mississippi Board of Pharmacy practicing within the scope as defined by state law. The present certification courses approved by the Board of Pharmacy are from twenty-four (24) to thirty (30) hours.

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All pharmacists, both the registered pharmacist with a doctorate and the registered, certified pharmacist must renew their specific disease management certifications every two years as required by Board of Pharmacy regulations. The present recertification course approved by the Board of Pharmacy is twenty to thirty hours.

Additionally, the pharmacist must provide a separate, distinct area conducive to privacy, e.g., a partitioned booth or a private room. Also the pharmacist must complete an enrollment packet and a provider agreement and receive a provider number from the Division of Medicaid.

The disease management services are reimbursed on a per encounter basis with an encounter averaging between fifteen and thirty minutes. The reimbursement is a flat fee established after reviewing Medicaid's physician fee schedule and reimbursement methodologies and fees of other states and third party payers. The number of encounters will be limited to twelve (12) per recipient per fiscal year.

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7a,b, & d. Home Health Care Services: Limited to a combined total of fifty (50) visits per fiscal year for intermittent or part-time nursing service provided by a home health agency (or a registered nurse when no home health agency exists in the area), or home health aide services provided by a home health agency, or physical therapy or speech pathology services provided by a home health agency. Occupational therapy and audiology services are not provided.

7c. Home Health Care Services: Medical equipment and appliances suitable for use in the home limited by: (1) Cost $150.00 or less, one lump sum; (2) Cost in excess of $150.00, payment will be on a rental purchase basis.

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9. Clinic Services:

(a) Ambulatory Surgical Centers

Those facility services associated with certain surgical procedures provided in Ambulatory Surgical Centers (ASC) as benefits available under Part B of Medicare authorized in Section 934 of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980.

Coverage of facility services in ambulatory surgical centers (ASC) is limited to those providers who have an agreement with HCFA under Medicare to participate as an ASC, and meets the conditions set forth in Subpart V of 42 CFR Part 416.

Only medically necessary services are covered under the Medicaid Program. Medical necessity will be determined by judging what is reasonable and necessary with reference to acceptable standards of medical practice and treatment of the recipient's disease or injury.

(b) Birthing Center Services

The services available in a birthing center are monitoring services (from labor to discharge for the woman and from birth to discharge for the baby) and monitoring services prior to the decision to transfer the woman to a hospital. Services in birthing centers are only appropriate for low risk pregnancies and deliveries. These services are available only to outpatients.

(c) Other Clinic Services

Family Planning, EPSDT, Children's Medical Program Perinatal High Risk Management and General Medical clinic services are available. Providers are clinics authorized by Section 41-3-15(5) of the Mississippi Code of 1972, as amended.

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